# House of Representatives

General Assembly

**File No. 225**

***January Session, 2017***

House Bill No. 7023

*House of Representatives, March 27, 2017*

The Committee on Insurance and Real Estate reported through REP. SCANLON of the 98th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

***AN ACT AUTHORIZING SHORT-TERM CARE GROUP INSURANCE POLICIES, PERMITTING HEALTH CARE CENTERS TO CHARGE COINSURANCE, AMENDING THE INSURERS REHABILITATION AND LIQUIDATION ACT AND REQUIRING THAT INSURERS ISSUE NOTICES TO INSUREDS REGARDING PERSONAL AND COMMERCIAL RISK POLICIES.***

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2017*) (a) As used in this section, "short-term care policy" means any group health insurance policy or certificate delivered or issued for delivery to any resident of this state that is designed to provide, within the terms and conditions of the policy or certificate, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for a period not exceeding three hundred days. "Short-term care policy" does not include any such policy or certificate that is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical

expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(b) (1) No short-term care policy or certificate shall be delivered or issued for delivery to any resident in this state, nor shall any application, rider or endorsement be used in connection with such policy or certificate, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the Insurance Commissioner. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to establish a procedure for reviewing such policies and certificates. The commissioner shall disapprove the use of such form at any time if the form does not conform to the requirements of law, or if the form contains a provision or provisions that are unfair or deceptive or that encourage misrepresentation of the policy or certificate. The commissioner shall notify, in writing, the insurer that has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy or certificate on or containing such form. The provisions of section 38a-19 of the general statutes shall apply to such orders.

(2) No rate filed under the provisions of subdivision (1) of this subsection shall be effective until it has been approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to prescribe standards to ensure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate if it fails to comply with such standards.

(c) (1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any short-term care policy or

certificate without providing, at the time of application or solicitation for purchase or sale of such coverage, full and fair written disclosure of the benefits and limitations of the policy or certificate.

(2) Each applicant for purchase of a short-term care policy or certificate shall sign an acknowledgment at the time of application for such policy or certificate that the company, society, corporation or center has provided the written disclosure required under this subsection to the applicant. If the method of application does not allow for such signature at the time of application, the applicant shall sign such acknowledgment not later than at the time of delivery of such policy or certificate.

(3) Except for a short-term care policy or certificate for which no applicable premium rate revision or rate schedule increases can be made, such disclosure shall include:

(A) A statement in not less than twelve-point bold face type that the policy or certificate does not provide long-term care insurance coverage and is not a long-term care insurance policy or certificate or a Connecticut Partnership for Long-Term Care insurance policy or certificate;

(B) A statement that the policy or certificate may be subject to rate increases in the future;

(C) An explanation of potential future premium rate revisions and the policyholder's or certificate holder's option in the event of a premium rate revision; and

(D) The premium rate or rate schedule applicable to the applicant for purchase of the short-term care policy or certificate that will be in effect until such company, society, corporation or center files a request with the commissioner for a revision to such premium rate or rate schedule.

(d) (1) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center

delivering, issuing for delivery, renewing, continuing or amending any short-term care policy or certificate in this state shall refuse to accept, or refuse to make reimbursement pursuant to, a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693 of the general statutes, in accordance with subdivision (7) of subsection (a) of section 19a-694 of the general statutes, solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(2) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any short-term care policy or certificate in this state shall, upon receipt of a written authorization executed by the insured, (A) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (B) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section. Such regulations shall include, but need not be limited to, (1) the permissible loss ratio for a short-term care policy or certificate, if any, (2) the permissible exclusionary periods for coverage under a short-term care policy or certificate, if any, (3) the circumstances under which a short-term care policy or certificate will be renewable, and (4) the benefits payable under a short-term care policy or certificate in relation to other insurance coverage that provides benefits to the insured.

Sec. 2. Section 38a-177 of the general statutes, as amended by section 22 of public act 16-213, is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

A health care center may provide health care (1) directly or by its employees or contractors licensed by this state to render such services, or by contract or by indemnity arrangement with any hospital, hospital service corporation, medical service corporation or person qualified and licensed to render any health care service or by both methods; **[**and**]** or (2) by other methods to the extent permitted under the Federal Health Maintenance Organization Act and the regulations adopted thereunder from time to time unless otherwise determined by the commissioner **[**by regulation**]** in regulations adopted in accordance with the provisions of chapter 54. A health care center may also enter into agreements with hospitals or individuals approved by their respective state regulating board, licensed to practice any of the healing arts, for the training of personnel under the direction of persons licensed to practice the profession or healing art. A health care center may also maintain a clinic or clinics for the prevention, study, diagnosis and treatment of human ailments and injuries by licensed persons and to promote medical, surgical, dental or scientific research and learning.

Sec. 3. Section 38a-323 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2017*):

(a) (1) No insurer shall refuse to renew any policy **[**which**]** that is subject to the requirements of sections 38a-663 to 38a-696, inclusive, unless such insurer or its agent sends, by registered or certified mail or by mail evidenced by a certificate of mailing, or delivers to the named insured, at the address shown in the policy, at least sixty days' advance notice of its intention not to renew. The notice of intent not to renew shall state or be accompanied by a statement specifying the reason for such nonrenewal. This section shall not apply: **[**(1)**]** (A) In case of nonpayment of premium; **[**(2)**]** (B) if the insured fails to pay any advance premium required by the insurer for renewal, provided, notwithstanding the failure of an insurer to comply with this subsection, with respect to automobile liability insurance policies the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies; or

[(3)] (C) if the policy is transferred from the insurer to an affiliate of such insurer for another policy with no interruption of coverage and contains the same terms, conditions and provisions, including policy limits, as the transferred policy, except that the insurer to which the policy is transferred shall not be prohibited from applying its rates and rating plans at the time of renewal. With respect to an automobile or homeowners policy, each insurer that sends or delivers a notice of nonrenewal pursuant to this subsection shall use the same method to send or deliver such notice to any third party designated pursuant to section 38a-323a.

(2) If an insurer intends to renew any policy that is subject to the requirements of sections 38a-663 to 38a-696, inclusive, under terms or conditions less favorable to the insured than provided under the existing policy, the insurer shall send a conditional renewal notice in the manner required for a notice of nonrenewal under subdivision (1) of this subsection. The conditional renewal notice shall clearly state or be accompanied by a statement clearly identifying any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles, under the renewal policy.

(b) (1) [On or before September 30, 1987, a] A premium billing notice for any policy subject to the requirements of sections 38a-663 to 38a-696, inclusive, except a workers' compensation policy, shall be mailed or delivered to the insured by the insurer or its agent not less than [forty-five days in advance of the renewal date or the anniversary date of the policy. On or after October 1, 1987, such notice shall be so mailed or delivered to the insured not less than] thirty days in advance of the policy's renewal or anniversary date, except that [on or after October 1, 1998,] such notice shall not be required for a commercial risk policy if the premium for the ensuing policy period is to increase less than ten per cent on an annual basis. The premium billing notice shall be based on the rates and rules applicable to the ensuing policy period and shall include a notice of transfer when the policy has been transferred from an insurer to an affiliate of such insurer pursuant to the provisions of [subdivision (3)] subparagraph (C) of subdivision (1)

of subsection (a) of this section. The provisions of this subsection shall apply to any such policy for which the annual premium was less than fifty thousand dollars for the preceding annual policy period.

(2) For purposes of any commercial risk policy subject to the requirements of sections 38a-663 to 38a-696, inclusive, except a workers' compensation policy, the mailing or delivery of a premium billing notice by an insurer's managing general agent, in accordance with the provisions of subdivision (1) of this subsection, shall constitute compliance by such insurer with said subdivision.

(c) Failure of the insurer or its agent to provide the insured with the required notice of nonrenewal or premium billing shall entitle the insured to: (1) Renewal of the policy for a term of not less than one year, and (2) the privilege of pro-rata cancellation at the lower of the current or previous year rates if exercised by the insured within sixty days from the renewal date or anniversary date. Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation **[**which**]** that existed before the effective date of such renewal.

(d) Notwithstanding the provisions of subsection (b) of this section, the advance notice period for any premium billing notice shall be at least sixty days for any liability insurance policy wherein a municipality is the named insured.

(e) Notwithstanding the provisions of subdivision (1) of subsection (a) of this section, the advance notice period for any refusal to renew any professional liability policy shall be at least ninety days.

(f) (1) No surplus lines insurer shall be deemed eligible to write coverage for risks as provided in sections 38a-741 to 38a-744, inclusive, and 38a-794, unless such surplus lines insurer complies with the requirements of this section.

(2) Notwithstanding the provisions of subsection (b) of this section, premium billing notices shall be provided by any surplus lines insurer

to the insured at least sixty days in advance of the renewal or anniversary date of the policy. Notices of nonrenewal or premium billing required by this section shall be provided by the surplus lines insurer or its duly authorized representative to the insured.

(3) Notwithstanding the provisions of subsection (c) of this section, failure of any surplus lines insurer to provide the insured with the required notice of nonrenewal or premium billing shall entitle the insured to an extension of the policy for a period of ninety days after the renewal or anniversary date of such policy, **[**provided**]** except that if the surplus lines insurer fails to provide the required notice on or before the renewal or anniversary date of such policy, the provisions of subsection (c) of this section shall apply. In the event of such a ninety-day extension of coverage, the premium for the extended period of coverage shall be the current rate or the previous rate, whichever is lower.

(g) For purposes of any market conduct examination performed pursuant to section 38a-15, the Insurance Commissioner may find an insurer to be in compliance with the requirements of this section upon a determination that such insurer made a good faith effort to so comply.

Sec. 4. Subsection (a) of section 38a-930 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) (1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under sections 38a-903 to 38a-961, inclusive, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation, or within two

years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) Any preference may be avoided by the liquidator if: (A) The insurer was insolvent at the time of the transfer; (B) the transfer was made within four months before the filing of the petition; (C) the creditor receiving it or to be benefited thereby or **[**his**]** such creditor's agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or (D) the creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not **[**he**]** such employee, attorney or other person held such position, or any shareholder holding directly or indirectly more than five per **[**centum**]** cent of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(3) Where the preference is voidable, the liquidator may recover the property, or if it has been converted, its value from any person who has received or converted the property, except where a bona fide purchaser or lienor has given less than fair equivalent value, **[**he**]** such purchaser or lienor shall have a lien upon the property to the extent of the consideration actually given by **[**him**]** such purchaser or lienor. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(4) Notwithstanding subdivisions (1) to (3), inclusive, of this subsection, a transfer pursuant to a commutation of a reinsurance agreement that is approved by the commissioner or the commissioner's designated appointee under section 38a-962d shall not be voidable as a preference. For the purposes of this subdivision, a commutation of a reinsurance agreement is the elimination of all

present and future obligations between the parties, arising from the reinsurance agreement, in exchange for a current consideration.

Sec. 5. Subsection (b) of section 38a-140 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(b) Whenever it appears to the commissioner that any person has committed a violation of sections 38a-129 to 38a-140, inclusive, as amended by this act, that so impairs the financial condition of a domestic insurance company as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, securityholders or the public, the commissioner may proceed as provided in **[**section 38a-18**]** chapter 704c to take possession of the property of such domestic insurance company and to conduct the business thereof.

Sec. 6. Section 38a-18 of the general statutes is repealed. (*Effective July 1, 2017*)

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *October 1, 2017* | New section |
| Sec. 2 | *July 1, 2017* | 38a-177 |
| Sec. 3 | *October 1, 2017* | 38a-323 |
| Sec. 4 | *July 1, 2017* | 38a-930(a) |
| Sec. 5 | *July 1, 2017* | 38a-140(b) |
| Sec. 6 | *July 1, 2017* | Repealer section |

***INS*** *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

### *OFA Fiscal Note*

***State Impact:*** None

***Municipal Impact:*** None

### *Explanation*

This bill authorizes the sale of short-term care group insurance policies in the state and makes a variety of other insurance related changes. There is no fiscal impact to the state or municipalities since this bill only affects the private insurance industry.

### *The Out Years*

***State Impact:*** None

***Municipal Impact:*** None

**OLR Bill Analysis**

**HB 7023**

***AN ACT AUTHORIZING SHORT-TERM CARE GROUP INSURANCE POLICIES, PERMITTING HEALTH CARE CENTERS TO CHARGE COINSURANCE, AMENDING THE INSURERS REHABILITATION AND LIQUIDATION ACT AND REQUIRING THAT INSURERS ISSUE NOTICES TO INSUREDS REGARDING PERSONAL AND COMMERCIAL RISK POLICIES.***

**SUMMARY**

This bill:

1. authorizes group short-term care insurance policies to be sold in Connecticut and establishes filing, disclosure, and other requirements identical to the those currently required of individual short-term care policies (§ 1);

2. allows health care centers (i.e., HMOs) to offer additional methods of health care, including by charging coinsurance, and allows the commissioner to adopt implementing regulations (§ 2);

3. requires an insurer to disclose certain comparative information before renewing a personal or commercial risk insurance policy with terms less favorable to the insured than his or her current policy (§ 3);

4. prohibits an insurer's liquidator from voiding commutation reinsurance agreements approved by the commissioner (§ 4);

5. allows the commissioner, after she finds a violation of certain insurance company holding and acquisition laws, to take possession of impaired (e.g., insolvent) insurers pursuant to the Insurers Rehabilitation and Liquidation Act (IRLA) (§ 5);

6. repeals an outdated provision on the commissioner's authority to act as a receiver for insolvent insurers and certain other insurers (§ 6); and

7. makes other technical, minor, and conforming changes.

EFFECTIVE DATE: July 1, 2017, except for the short-term care and personal and commercial risk disclosure provisions, which take effect October 1, 2017.

## SHORT TERM CARE INSURANCE

The bill establishes group "short-term care" insurance policies and creates filing, disclosure, and other requirements identical to those currently required of individual short-term care policies. These policies provide coverage for 300 days or less, on an expense-incurred, indemnity, or prepaid basis, for necessary care or treatment of an injury, illness, or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital. They do not include policies primarily providing (1) supplemental Medicare coverage (i.e., Medigap coverage) or (2) coverage for basic medical-surgical expenses, hospital confinement indemnities, major medical expenses, disability income protection, accidents only, specified accidents, or limited benefits.

### *FILING REQUIREMENTS*

The bill requires (1) insurers and other entities (fraternal benefit societies, hospital service corporations, medical service corporations, and health care centers) to file copies of short-term care insurance policy forms, risk classifications, and premium rates with the insurance commissioner before delivering or issuing them to Connecticut residents and (2) the insurance commissioner to adopt regulations establishing review procedures for these policies. ("Form" is a term of art that includes policies, riders, and endorsements.)

#### *Approval of Rate Filings*

The commissioner must adopt regulations ensuring rates are not excessive, inadequate, or unfairly discriminatory. Rates are not

effective until she approves them in accordance with these regulations, and the bill authorizes her to disapprove rates failing to meet the standards in the regulations.

### *Disapproving Forms*

Under the bill, the commissioner must reject any forms that (1) do not comply with the law, (2) contain unfair or deceptive provisions, or (3) contain provisions that misrepresent the policy. In such cases, she must notify the insurer in writing, specifying the reasons for her disapproval and ordering that no short-term care insurer deliver or issue a Connecticut policy on, or containing, the disapproved form.

Any insurer disagreeing with the commissioner may request a hearing under existing insurance provisions.

### *Required Disclosure*

The bill prohibits insurers and other issuing entities from issuing or delivering a short-term care policy without first providing, at the time of solicitation or application, a full and fair written disclosure of the policy's benefits and limitations. For short-term care policies with premium rate revisions or rate schedule increases, the disclosure must include:

1. a statement, in at least 12-point bold face type, that the policy does not provide long-term care insurance coverage and is not a long-term care insurance policy or a Connecticut Partnership for Long-Term Care insurance policy;

2. a statement that the policy may be subject to future rate increases; including an explanation of potential future premium rate revisions and the policyholder's subsequent options; and

3. the premium rate or rate schedule applicable to the applicant until the issuer files a request with the commissioner for a premium rate or rate schedule revision.

Applicants must sign an acknowledgment, at the time of the

application, that the insurer or other issuing entity has disclosed this information. If the application method does not allow for a signature (e. g., an electronic application), the applicant must sign an acknowledgement before the policy is delivered.

### *Regulations*

The bill requires the commissioner to adopt implementing regulations for short-term care insurance policies, including (1) permissible loss ratios and exclusionary periods, (2) circumstances when a policy is renewable, and (3) the benefits payable in relation to an insured's other insurance coverage.

### *Managed Residential Communities*

The bill prohibits insurers and other entities from refusing to accept or reimburse claims submitted by, or prepared with the help of, a managed residential community solely because the community submits or prepares the claim. Upon an insured's written request, these issuing entities must also (1) disclose to an insured's managed care community the insured's coverage eligibility and (2) provide the community with a copy of an initial claim acceptance or denial at the same time they provide one to the insured.

## HEALTH CARE CENTERS

Under current law, health care centers (i.e., HMOs) may provide health care (1) directly or indirectly and (2) by methods permitted under the federal Health Maintenance Organization Act unless otherwise determined by regulation. The HMO Act, among other things, requires, payments by insureds to be fixed without regard to the frequency, extent, or kind of health service received.

The bill instead allows HMOs to offer health care services (1) directly or indirectly, or (2) by methods permitted under the act unless otherwise determined by regulation.

## PERSONAL OR COMMERCIAL RISK INSURANCE POLICY DISCLOSURE

Under the bill, an insurer renewing a personal or commercial risk

insurance policy less favorable than an insured's current policy must send a renewal notice clearly identifying any reduction in coverage limits and any added or revised coverage provisions that reduce coverage or increase deductibles.

By law, renewal notices must be sent registered or certified mail, or proven by a certificate of mailing, to the address shown in the policy at least sixty days before renewal.

## COMMUTATION REINSURANCE AGREEMENTS

Under current law, an insurer in hazardous financial condition or that meets certain other criteria may be placed under the insurance commissioner's supervision. If the supervised insurer is liquidated, the court-appointed liquidator (e.g., the commissioner) may void certain transfers that unfairly benefit some creditors over others, as long as the transfers are made:

1. within one year of the liquidation date or
2. for insurers already subject to a rehabilitation order, within two years of the rehabilitation petition or one year from the liquidation petition, whichever is shorter.

Under the bill, transfers under commutations of reinsurance agreements approved by the commissioner or her designee may not be voided. A commutation agreement eliminates all present and future reinsurance obligations between the parties in exchange for current consideration. (Reinsurance transfers one party's insurance risk to another party.)

## IRLA AND REPEALER

The bill (1) allows the commissioner to take possession of an insurer in certain situations, including insolvency, pursuant to the Insurers Rehabilitation and Liquidation Act instead of an outdated provision, and (2) repeals the outdated provision (CGS § 38a-18). IRLA generally provides more detailed procedures for when and how the commissioner can supervise, rehabilitate, or liquidate an insurance

company.

## COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 20 Nay 0 (03/07/2017)